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Deposited in DRO:

15 January 2019

Version of attached file:

Accepted Version

Peer-review status of attached file:

Peer-reviewed

Citation for published item:

Atkinson, S. (2017) 'Mixing and fixing : managing and imagining the body in a global world.', in Global health and geographical imaginaries. London: Routledge, pp. 54-71. Routledge studies in public health.

Further information on publisher's website:

<https://www.routledge.com/9781138852389>

Publisher's copyright statement:

This is an Accepted Manuscript of a book chapter published by Routledge in Global health and geographical imaginaries on 6 March 2017 available online: <https://www.routledge.com/9781138852389>

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Mixing and fixing: managing and imagining the body in a global world

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A defining characteristic of the globalisation of health care provision has been the movement of people for health-related purposes involving both health personnel seeking improved terms of employment within a globalising labour market and health service users seeking improved access, quality or costs across a global market for major medical interventions. This emergence of new markets for medical care at a global scale reflects a combination of the increasing ease of travel, the development of biomedical technologies for reproduction and reconstruction of the body and the liberalisation of cross-border trade. As such, these new opportunities for medical travel involve multiple geographies of the body including concerns of borders and boundaries, ethics and inequalities, resource flows and the nature of care at a global scale. Geographers of health have begun to explore the issues that arise from this rapid growth in medical travel but to-date mostly have directed research attention to the challenges and opportunities for those countries providing services for medical tourists (Johnston et al., 2015a,b) and to the complexities of how the relations of neoliberalism and the market unfold in different settings (Parry et al., 2015). This chapter engages the practices of medical tourism involving the exchange of body parts through attention to scarcity and inter-corporeality in terms of their real and imagined relations and tensions. Scarcity is a fundamental relation underpinning medical tourism in which not only timely and less costly care is sourced but also scarce and vital bodily material. Inter-corporeality has received far less research attention in terms of how medical intervention through sharing of body parts, fluids or reproductive processes confronts and reworks traditions of nationalised and racialised identities to enable practices that both revalue and re-exploit other bodies. This attention to how various types of borders are dissolved, redrawn and policed as bodies are brought together, often literally, in contemporary and future global health markets complements existing geographical work on global health by exploring how we do and might imagine, confront and negotiate the relations and tensions of scarcity and inter-corporeality arising in this kind of medical tourism. The chapter thus has as its primary focus the lived and imagined ways of framing

the relations and tensions of scarcity and inter-corporeality in the case of transplant tourism.

Literary fiction and film are an important source to exploit for those interested in not only the lived experiences but also the imaginaries of scarcity and inter-corporeality in relation to organ donation and procurement. Such creative forms situated in present and future fictional worlds afford nuanced, rich explorations of the multiple and complex ways of imagining, confronting and negotiating scarcity and inter-corporeality. . These worlds, and the tales of events and lives within them, are here treated as complementary empirical resources to the narrative accounts of human experience captured through interview-based or ethnographic methodologies. A novel or film gives the space for the characters to tell their stories and display their emotions, situated in particular times, places and relationships, but these stories are also complemented with an authorial commentary, verbal or visual observations, as well as the opportunity to make explicit hidden values or unpredictable reactions. These are approaches that emphasise how in negotiating our own values and practices, we draw on multiple options and resources, 'culturally available narratives, stories, scripts, discourses, systems of knowledge or... ideologies.' (Searle, 2003: 514). Literary fiction and film offer us explorations of negotiating such resources and experiences and as such constitute a data source to be mined following the traditions of early geographical engagements with the humanities (Marston and De Leeuw, 2013). Drawing on literary fiction and film in this way can open up a field of geohumanities and health within wider moves by the discipline to revisit our relationship with the arts and humanities (Dear et al., 2011; Marston and De Leeuw, 2013). Geographers working on health and medicine have had some limited direct engagement with this trend: drawing on literary fiction in relation to how landscapes and places relate to healing and health (Gesler, 2003; Tonnellier and Curtis, 2005; Foley, 2015); engagements with new health practices as a form of spirituality (Philo et al., 2015); participation in the creative arts as contributing to health or wellbeing (Atkinson and Robson, 2012; Atkinson and Scott, 2015). Literary fiction and film also offer alternative engagements and future imaginings through which to expand our available options and resources and to explore their various implications. In this sense, literary fiction and film not only provide a nuanced mirror to and exploration of existing discourses but exercise their own agency in influencing how we engage, celebrate or caution against alternative modes of practice (Kitzinger, 2010). Literary fiction and film that have broached issues of transplant technologies and trade include, on the one hand, elaborations of existing discourses of scarcity and inter-

corporeality and, on the other, science fiction explorations of new and different responses to the challenges of organ procurement and donation. Thus, the chapter, as a side-effect, also makes a secondary contribution to the geographies of global health in the engagement with the geohumanities, new sources of data and new modes of agency in how imaginary worlds reflect and inform our practices at local and global scales (Atkinson, 2016).

Geographies of medical tourism

Movement from one country to another for the purposes of accessing medical care is not a new phenomenon; the elite of low and middle income countries have always sought the most recent technologies and higher quality care that are unavailable locally from other countries with better resourced health services, a trend that continues (Snyder et al., 2015a). What is new is the rapid rise in the numbers of those seeking medical intervention in countries other than their own and particularly the rise in the movement of nationals from high income countries seeking expensive medical interventions at lower costs in middle and low income countries. In some cases, patients may be referred from their own health care system for treatment in another country through a bilateral agreement between the countries concerned; some seek health care from a country other than their own as expatriates currently living there or as tourists taken ill during their vacations and for whom health costs are likely to be covered by insurance. However, the phenomenon of interest is the expansion of a new health care sector catering to private patients who intentionally elect to self-refer for medical interventions across international borders and usually cover the costs for such services as an out-of-pocket payment. This is the phenomenon referred to as medical tourism which is estimated to represent 30-50% of all medical care provided to foreigners (OECD 2011) but which is particularly significant in terms of the potential impact on the national health service given the demand is for more intensive, costly and expert treatments (NaRong and NaRong, 2011). For example, the Centers for Disease Control and Prevention (CDC) in the USA estimate that up to 750,000 residents of the United States now travel abroad for care each year, a figure likely to be a conservative estimate as much of the travel is likely to go undocumented (CDC, 2015); Thailand witnessed a growth in medical tourism over a decade from almost none to approaching half a million (NaRong and NaRong, 2011).

Motivations for travellers include much reduced costs, quicker treatment given long waiting lists at home, availability of the latest technological expertise or access to treatments not

permitted in the home country (OECD, 2011; Petersen and Seear, 2011; Petersen et al., 2014; Snyder et al., 2014). The rise of medical tourism alters the global, regional and local landscapes of healthcare provision and inequalities in access to that provision. The industry has been characterised by the emergence not only of new clinics and hospitals in provider countries but also a range of associated industries that embed the central medical intervention. Travellers need to be assured of high quality care and a new industry of facilitation companies serves to meet this demand (Holm and Snyder, 2015). Some interventions involve a recovery period in country which is supported through an emerging industry of small-scale recovery 'care homes' offering a more personal care and an attractive setting, reflecting the 'tourism' part of the label (Ackerman, 2010). In terms of global health governance, regulating cross-border medical movements and practices is particularly challenging in the absence of standardised international definitions of the relevant components, the historical trajectories and specificities of national regulation of medical practice and the emergence of an international market for the provision of health care in which competition to attract foreign investment may promote deregulation and a globally expressed 'race-to-the-bottom.' (Helble, 2011; Schneider, 2015; Whittaker, 2010).

Geographers have begun to engage the phenomenon of medical tourism through two broad approaches or fields of study: as part of health systems and health services research (for example, Adams et al., 2015a) and as part of research on neoliberalisation and globalisation (for example, Greenhough et al., 2015). These, of course, are not discrete categories of research and there is considerable overlap but they do reflect the primary focus and audiences for the research undertaken. The research group on medical tourism based at Simon Fraser University has produced a substantial body of research since 2010 on a range of health care concerns including the motivations to travel for health care (Cameron et al., 2014; Adams et al., 2015b), the potential benefits and pitfalls of developing a medical tourism sector for low and middle income countries (Adams et al., 2015a; Johnston et al., 2015a, b), the implications of outward-bound medical tourism for the health systems of low and middle income countries (Snyder et al., 2015a), the patterns of health worker migrations related to medical tourism (Crooks et al., 2015; Snyder et al., 2015b), the implications of medical tourism for family physicians in tourists' countries of origin (Snyder et al., 2013) and the ethical, legal and regulatory issues and choices to be negotiated (Adams et al., 2015a). This body of research emphasises the need for attention to the socio-spatial particularities and variations of different medical tourism settings. These studies clearly locate the emerging markets for medical tourism within the context of

globalisation but predominantly talk to the community concerned with health systems and associated policy issues (Adams et al., 2015a).

The second body of work takes the processes of globalisation and neoliberalisation and their varied and situated expressions as the primary focus of their research. This work examines how globalisation and the tenets of neoliberal politics combine with new technologies of communication and biomedicine to reconfigure the provision and access of health care including the rapid increase in the movement of medical patients and professionals, biomedical services and medically relevant body parts (Greenhough et al., 2015; Parry et al., 2015). Research has attended closely to the positionality of those involved in the markets for medical tourism to better understanding the differentiated landscapes shaping their choices, decisions and experiences (Parry, 2008). The growth of medical tourism as a market reflects and exemplifies the values of a neoliberal regime: the privileging of individual autonomy as a policy goal; the centrality of consumer choice within a free market economy; the slimming down of state public service provision in favour of privatisation, franchising, contract or out-sourcing, including off-shore, of elements in service provision; support for greater flexibility of labour markets and labour provision (Greenhough et al., 2015). However, in the context of a globalising free market for health care, the opportunities to realise the claims made for autonomy and choice are unequally distributed and follow existing lines of inequality including of gender, place and culture (England, 2015; Greenhough et al., 2015; Holliday et al., 2015). This second strand of geographical work on medical tourism is mirrored across the social sciences more widely (see for example work in anthropology by Scheper-Hughes, 2002, 2003, and in sociology by Whittaker, 2008), and the dominant analytical discourse has similarly been that seeking medical care through a global market illuminates how the processes of neoliberalisation play out in different settings. Research across the social sciences has thus attended to the different dimensions of unevenness in the dynamics of global medical markets thereby reaffirming the continued importance of context, history and embodiment.

This unevenness in new markets for medical tourism may also be expressed through variation across different forms of medical intervention. The specific practices of medicine insist on foregrounding the materiality of bodies; when we engage the particular medical technologies that involve the surgical transfer of parts from one body to another in what Waldby termed biomedically engineered inter-corporeality (Waldby, 2002), two further aspects of the unevenness of new markets demand our analytical attention. Waldby

(2002) specifically emphasises the ways in which embodied identity is produced through social relations and, drawing on anthropological studies of tissue donations, critiques the over-emphasis on the visual in producing embodied identities at the expense of what she calls introceptive data, and perhaps particularly those that become foregrounded in the event of ill-health experiences. Secondly, the availability of such body matter for certain forms of donation, such as organ transplants, is already significantly behind demand, a shortfall which will only increase in the future given ageing populations and improved medical technologies. Taking these two aspects together, the new possibilities to reinvent and recycle ourselves through replacing or donating body parts, and for fixing bodies through mixing bodies, are accompanied not only by new tensions related to resource flows, inequalities and the nature of care at a global scale; but also by reworking our understandings of sameness and difference in bodily matter. The accommodations made around such tensions in turn are underpinned by emerging new and reworked rhetorics and discourses that enable or block different practices for the procurement of scarce bodily matter through explicit forms of argumentation and implicit or hidden assumptions.

Tensions of Scarcity

The forms of discourse which dominate in relation to organ procurement and donation have a distinct pattern in terms of their social and spatial distribution. The dominant analytical discourse related to the global movement of organs for transplant reflects work on medical tourism more widely and continues the emphasis on the workings of globalisation, trade liberalisation and consumer choice. However, this discourse is infused with a far stronger moral resonance than is generally the case in other areas of medical tourism, a moral infusion that is largely condemnatory, a matter for outrage and abhorrence. At its most extreme, the global movements of organs for transplant have been condemned as 'new forms of late modern cannibalism' (Scheper-Hughes, 2002:1), reflecting the marked tendency for globally scarce organs to move along lines of inequality, from poor to rich, south to north, and to some extent women to men (Scheper-Hughes, 2003). This is a movement that may be illegal and as such invisible, informal or pursued through unethical procedures without consent, or achieved through direct and indirect coercion within a context of structural violence (Galtung, 1969). In marked contrast, the analytical discourse that dominates within high-income countries, or those countries successful in largely upholding regulation, is celebratory through the language of the gift, giving life and hope (Svaenaeus, 2010). Those donating are positioned as generous, even

heroic, and recipients as fortunate and saved. These rhetorics of the gift and voluntarism have their roots in the post-second world war movement for social solidarity and welfare provisions, which in relation to donation was mobilised and theorised as the 'gift relationship' in the influential work of Richard Titmuss (Titmuss, 1970; cf. Fontaine, 2002; Reubi, 2012). The discourse of the generosity or social citizenry of the gift as the basis for donation constitutes the desirable form of organ transplant programmes against which the coerced or commercialised procurement of organs are juxtaposed and against which such self-interest, greed or exploitation appear particularly heinous.

Creative imaginings through film or fiction offer us various entry points in developing a global and critical engagement with these discourses. As a form of knowledge, these media can bring their audiences into close emotional engagement with the realities of living as others, in other bodies, in other social and economic spaces and in other encounters with the processes of globalisation and neoliberalisation. Literature and film enable their audiences to encounter the issues, to confront their own reactions and to reflect on the implications of the rhetoric for different practices. As such, engagement with the creative imaginings of relatively unfamiliar aspects of contemporary societies can illuminate the ways we do and might practice biomedical technologies. Moreover, as the conduit for our reflections on different practices, these creative imaginings have their own agency as strategies themselves for how we encounter and engage other bodies. The exploitative element in the global organ trade has been drawn on through the genres of the thriller or horror in film. Stephen Frears' thriller '*Dirty, Pretty Things*' (2002), for example, accompanies the various vulnerabilities to exploitation in the lives of undocumented immigrants in London, including to coercion as donors in an illegal organ trade. The protagonists escape, but only by exacting the violence of forced kidney donation back onto the perpetrators of violence. This may make for a sense of satisfaction in cinematic terms through the personal resolution of the problems faced by those characters who have won our sympathies, but only addresses the wider challenges of the underground illegal trade through evoking audience abhorrence.

In a full horror genre, John Stockwell's film '*Turistas*' (2006) draws on global inequalities in the organ trade in a different exploration of revenge. The tourists of the title are young, middle-class backpackers from the United States who are kidnapped for the purpose of organ extraction from which one of them dies before they manage to escape. However, in this film, the motivation of the gang extracting the organs is not one of self-interest or

financial profit but to redress inequalities in the global flow of organs for transplant. They claim that organs have been stolen from the poor in Brazil for the benefit of rich foreigners and it is time for those countries to pay back. The organs they extract will be taken for donation to the poor in Brazil and as such the violence is enacted in the pursuit of social justice. This inversion of an argument for social justice into an act of violence and coercion serves to undermine any audience sympathies for those fighting for human rights. Whilst exposing some of the issues of a clandestine global trade in organs, both films in different ways effect an important relocation of exploitation, and responsibility for exploitation, away from the wider context of global inequalities and down onto the more localised activities of a criminal sub-class.

Literary explorations of the gift of donation focus on the personal experiential and emotional journeys of those most closely involved. Two novels suggest the emergence of a donation literary genre in that both follow the journeys of several characters connected either to a child who has suddenly and unexpectedly died or to an ill child who benefits from the subsequent act of donation (Snelling, 2008; Wolfson, 2011). The focus on children, a category of person that is both vulnerable and innocent of their ill-health condition, underscores the loss and the benefit by maximising both in terms of the years of life that have been lost and the years of life that are regained in relation to what is considered a normal lifespan. The focus on children thus effectively promotes the gifting of organs to the reader by rendering both loss and benefit wholly unambiguous. At the same time, there is a further benefit in the suggestion that the act of donation, in saving the life of another child, may afford the relatives of the deceased some degree of comfort in the longer-term. At the end of Jill Wolfson's book, *'Cold hands, warm heart'* (2011), the mother of the deceased child lays her head against the chest of the recipient child to hear the beating heart of her daughter, the gift that has enabled another young life to be lived.

Part of the underlying difference in these two dominant discourses relates to what might be considered a normal lifespan. While this clearly varies across time and space, the idea itself of 'premature death' is relatively recent, having emerged together with the development of techniques to assess population mortality and longevity rates. As such, the perception of a 'premature death' is 'intimately bound to the spatial and temporal regularities of mortality' (Tyner, 2015: 361). The threat of premature death can be resisted by some better than others, that is, the resources to prevent premature death can be accessed by some better than others in the context of scarcity (Kearns and Reid-Henry,

2009). Whilst attention has been given to the illegal trade in organs, the growing market in medical tourism may in reality be the greater challenge to global inequalities in access to organs. Cohen (1999) argued that in the case of the market of live kidney donation in India, the problem for the market was less one of organ scarcity but rather one of recipient scarcity. Those willing to sell were many given their conditions of poverty and debt; those able to pay the costs of transplantation were fewer. As advances in the technologies of organ transplant enable markets for organs to operate globally, the shortage of local buyers becomes less of an issue.

The current debates on organ procurement now centre on how to increase legal donation by moving beyond the rhetoric of the gift and two possible policy routes attract the most attention: the opt-out system and the legal sale of organs. A procurement system based on an opt-out register, rather than the more common voluntary opt-in system has been adopted by only a few countries to-date including Spain and Finland (Lindberg, 2013). Similarly, only one country, Iran, has to-date made it legal to sell a kidney, a permission that is actively encouraged through further state incentives to the seller over and above the payment from the buyer. Iran argues that the policy has eradicated its long waiting lists; others argue that the legalised trade does nothing to address the disproportionate sale of kidneys by the same sub-group of the poor and vulnerable that characterise illegal markets (Alesi and Muzi, 2015). Whilst legal systems, such as that of the United Kingdom, formally deny property rights over the human body, such debates broach related areas of contestation over who owns the body and who can exercise consent: opt-out systems effectively position by default the body as belonging to the state after death, albeit with a recognition of personal ownership through a non-consent option; in practice, the medical profession is sensitive to the wishes of the deceased relatives, even to the extent of overruling the deceased's own wishes, at which point ownership over the body is effectively held by the extended kinship group (BBC, 2013; Guardian, 2015); by contrast arguments for a legalised market for organs reassert private ownership of the body. The internet also offers routes through which individuals may reassert the private ownership of their body parts by providing virtual spaces in which would-be donors and patients needing an organ, and particularly a kidney, can now meet. This not only moves the act of gifting onto an international scale, but perhaps more importantly permits donors to select the recipients of their body parts. This option to determine the recipient of a donation is implicitly explored in Gabriele Muccino's film, *'Seven Pounds'* (2008), Ben has identified seven strangers to benefit after his suicide, including from his body parts. But first he wants to make sure they

are worthy of his gift, invoking a long tradition of judging who is and is not deserving of charity. Moreover, *'Seven Pounds'* is an excellent example of how imaginary explorations have their own agency because the film privileges certain motivations for donation over others. Ben initially seeks redemption for his negligent driving which was responsible for seven deaths, but falls in love with one of his beneficiaries and finally sacrifices himself for the sake of a loved and known other. This personalised motive is positioned in the film as superior to a motive of giving back, implicitly undermining the value of donating to society or to humanity. This undermining of a more social commitment, of the giving-over of the body through its excorporations to a social body (Cohen, 2013), aligns with the tenets of a neoliberal project whilst still adhering to the rhetoric of the heroic gift, and, as such, represents a local accommodation of the distinction between the two dominant analytical discourses of global exploitation and national beatific gifting.

Tensions of Inter-corporeality

Whether cautionary, condemnatory or celebratory, these discourses share two important and related features: first, they focus on the 'donation' (voluntary or coerced) as the critical moment in the transplantation process and secondly, the medical act is implicitly presented as a success, the desired route to the recovery of health and of normal living, and the happy end-point to the story. However, social scientists need to pause and interrogate this happy ending and reintroduce the role of biology into our accounts.

Body parts are not as easily interchangeable as explorations of transplants within either neoliberalisation or gifting accounts imply. The body has a fierce system for policing its boundaries through the immune system; the technologies for coinciding with or by-passing the processes of the immune system have been one of the major successes in transplant medicine. The successes of the earliest transplants depended on a very close matching of blood and human leukocyte antigens, and it remains the case that a family member may be the optimal source for an organ. The expansion of modern transplant medicine's potential has come about through the development of pharmacological technologies that can effect a total suppression of the immune system, enabling the introduced organ to pass by the body's rigorous border controls. The immune system and the immunosuppressant drugs, such as cyclosporine, are vital central actants within the processes of transplantation but have received limited attention within social analyses compared with the procurement of organs (for exceptions, see Cohen, 2001; Kierans, 2011). It is the power of the action of these immunosuppressant pharmaceuticals that has

widened the pool of potential organ donors for any given recipient and, as such, that underpins the possibility of the gift of life from unrelated strangers or the purchase of an organ from those living in poverty in distant countries. Similarly, the organ transplantation process does not end at the point of donation and transfer to the recipient; the recipient must continue to take immunosuppressant drugs for the rest of their lives and these drugs not only suppress rejection of the introduced organ, but rejection of all other noxious entities leaving transplant recipients particularly vulnerable to other causes of ill-health (Cohen, 2001; Kierans, 2011). This dependency on pharmacological technologies to avoid the rejection of the introduced organ constantly reasserts and reconstitutes a corporeal relation between the recipient and their organ donor in which the presence of the other somewhat paradoxically both enables and threatens life.

Despite the power of immunosuppressant technologies, physicians still match on various biomarkers to maximise the success of transplantation. The relocation of the medical gaze to the molecular scale of bodies is argued to be reworking the forms of biopolitics in the governance of life itself (Rose, 2007). The interactions of molecular and genetic variations with existing socio-political categories of gender and race have generated debate as to whether this relocated gaze may offer an emancipatory discourse in the face of racialised bodies (Reardon, 2012; Skinner, 2006). The possibility to excorporate body parts for the benefit of an unknown other and of incorporating part of the body of an unknown other confronts potential donors and recipients with their own prejudices about different, and particularly racialised, bodies. Whilst Waldby (2002) argued that inter-corporeality in organ exchange may sometimes generate feelings of kinship or profound destabilisations of identity, the growing global market for organs through medical tourism, whether legal or illegal, suggests a detachment or even disregard for the body of the donor.

The exploitation of one set of people by another is not a new phenomenon, but the emergence of a justification for such exploitation through a racialised discourse emerged to resolve a tension between the universal humanism of the enlightenment and the inequalities generated by European imperialism and capitalism (Kobayashi, 2004; Skinner, 2006). The construction of 'race' as a category predicated on biological difference became naturalised so as to construct the bodies of those colonised as inferior and therefore justifiably subjugated, governed or even enslaved (Kobayashi and Peake, 1994). The mixing of bodies through sexual reproduction within this discourse was often legally prohibited and certainly socially condemned but genomic projects have demonstrated the

high levels that nonetheless occurred and which give witness to the exploitation of women of colour by colonial men (Skinner, 2006). This historic racialization of bodies in social and political life perpetuates into the present through continued discrimination and resultant inequalities both within and between nation-states. The practice of blurring the social and biological continues within organ transplantation through the reworked category of 'ethnicity' in those countries, such as the United Kingdom, where the ethnic classification of persons is used as a proxy for the molecular specificities of tissue matching. In other words, potential donors and recipients are matched by the social proxy of 'ethnicity' rather than by the assessment of relevant biological measures (Kierans, 2013).

In medical tourism, the significance of a racialised identity is reflected in how reproductive services are sought through the global market. Whereas new centres for medical tourism that cater for a range of surgical procedures are being intentionally developed in post-colonial low and middle income countries, white Europeans seeking reproductive donations through the global market predominantly prefer services from other European countries (Gunnarson Payne, 2015). In this respect, although the maintenance of a family line through genetic relatedness is side-stepped, the maintenance of the family genealogy through racialised affiliation remains significant. This is in striking contrast to the practice of those seeking organs to increase their survivability who are willing to accept and incorporate an organ of a racialised other in concert with the incorporation of immunosuppressant drugs that may be seen as suppressing the otherness of the transplant organ. To a great extent, the ability to incorporate an organ that originates from a body that is different in molecular terms, whether or not it also differs culturally, ethnically and economically, relies on an understanding of the workings of the body through a mechanical metaphor. Whereas social scientists have challenged biomedicine for seeing bodies only in terms of their component parts and for a binary distinction between body and mind, organ transplantation reasserts these: body parts can function as spare parts, transferable from one setting to another; identity is independent of the origin of bodily material, although not of overall bodily health. Legal frameworks that insist on the renunciation of ownership of body matter once donated similarly support an understanding of bodily matter as separable from identity (Lock, 2002). The extent to which bodily matter may 'retain some of the values of personhood for many if not most donors and recipients' as argued by Waldby (2002: 240) may vary by type of donation and the particular social role accorded to that tissue by society.

There are few accounts of medical tourism for transplantation. Those that exist, as with much of contemporary research, tend to end at the point that an organ has been sourced and the operation undertaken. The biography, *'Larry's Kidney'* (Rose, 2009), follows the journey of US citizen Larry who travels with his cousin, who is the book's narrator, to source a kidney and a transplantation operation illegally on the global market. The account follows their experiences and emotions in negotiating the health system and culture of a different country and the cousins' relationship with each other in this context. These aspects have been examined through a lens of emotional geographies in terms of confronting otherness (Kingsbury et al., 2012), but not in terms of incorporating otherness, which does not emerge as one of the significant emotional dimensions in the account of Larry's search for a kidney. Receiving and incorporating the organs of a nationally different other seems to involve less of Waldby's 'complex modification of the recipient's embodied identity' (2002: 241) than of the emotional and cross-cultural journey that took Larry to the point of receiving a kidney transplant in the first place. That said, Larry's subsequent experience as a post-transplant patient gets almost no attention and is noted only briefly in an epilogue, indicating his continued ill-health and dependency on immunosuppressants. There has similarly been very little empirical research on post-transplantation experiences that might elaborate the complexities and variations of Waldby's introceptive experiences of transplant incorporations. One of the few studies highlights the continued challenges for organ recipients; as one post-transplantation informant in Mexico states, 'I thought I would be healthy again, and normal, but really I'm just a different kind of patient now' (Crowley-Matoka, 2005: 821).

There is then a bias in the analytical approaches to the global inequalities in organ transplantation that privileges the suffering of donors and underplays that of recipients and as such generates a further form of inequality, that of an inequality of concern (Kierans, 2011). The discourse of the gift as an altruistic act of beneficence was premised on selective readings of anthropology (Titmuss, 1970; Fontaine, 2002) and is further complemented by anthropological understandings of the gift as part of the social relations of reciprocal exchange, obligation and expectation (Sharp and Randhawa, 2014). The limited ethnographic work that exists with transplant recipients has been framed within the discourse of the gift to disclose the modes of reciprocity that emerge within kin networks and the sense of obligation that is felt by recipients to their donor and to the organ itself to follow healthy lifestyle behaviours. Kierans (2011), drawing together anthropological work undertaken in Ireland, Mexico and the Philippines, emphasises the challenges that face

the recipients of organ transplantation post-operation, the lack of concern within some health care systems and the guilt that recipients feel in the face of expectations by others that they are now restored to health when in reality they are still quite unwell. As Kierans argues in summary, 'Transplantation does extend life, but the lives so extended are radically altered in the process.' (2011: 1473).

Tensions of Scarcity and Inter-corporeality

Improving organ transplantation, improving lives post-transplantation, will depend on improving the subtlety of immunosuppressant drug actions or better still removing the need for them altogether. The perfect organ match is likely to remain the organ of the identical other, the identical twin or, since most people do not have identical twins, the identical clone. Creative imaginings of future dystopic societies have resolved the tensions of scarcity and inter-corporeality through the production and medical exploitation of a parallel, cloned sub-class to maintain a population's wellbeing. The narrative of these imaginings hangs on an unequivocal moral position that these practices are to be condemned and the story-line follows how humanity is restored to the exploited bodies. The insights for a critical engagement with contemporary practices of a global market for organ transplantation come not from the condemnation but from the various discourses that are used to justify treating and categorising their supplier population as non-human.

Three examples illustrate this resolution of the tensions of scarcity and inter-corporeality through cloning in future dystopic societies. In the *New Earth* of the BBC's *Dr Who* (2002) the hospital run by cat-like nuns have the knowledge to cure all human ailments. However the nuns' healing expertise reflects an accelerated rate of knowledge acquisition brought about by experimenting on thousands of human clones which they secretly grow in vaults and infect with diseases. The actions of the sisters are illegal in *New Earth* but no-one is looking too closely at the source of the evident gains. In Michael Bay's *The Island* (2005), customers pay for the growth of customised organs but the scientist-businessman finds more profitable to produce whole body clones. Similarly to *New Earth*, the exploitation of clones is illegal but again we intuit a society content not to look too closely, a suspicion supported when the non-clone customer is confronted with the reality of his clone double and finds himself unable to act ethically in the face of his potential mortality. By contrast, the society of Kazuo Ishiguro's novel *Never Let Me Go* (2005) openly sanctions cloning to provide a customised organ supply and, as such, requires different and collective strategies to justify the clones' subjugation to organ harvesting. Although the clones are

well cared for, especially as they grow up, society's discourses and rhetoric must categorise them as sub-human, even for those most intimately involved with their childhoods. Ishiguro displays the effectiveness of such categorisation: a woman who collects their art work displays her abhorrence; their head-teacher admits that she always had to steel herself to face them.

For us as audience, the location of these scenarios into fictitious futures presents a series of possible, but improbable, undesirable outcomes that we need and indeed will avoid; the audience agrees with the condemnation and reaffirms a need for public debate around new technologies and effective regulation. But treating these examples of exploitation as improbably cautionary tales may overstate both the extent of our condemnation and the power of regulation. Even in the setting in which the clones are most abused, the morality is tinged with a troubling ambiguity. The Sisters in *Dr. Who* do not act from self-interest; they act from a professional commitment and compassion towards their human patients and justify their actions by arguing that more humane methods of research would have been too slow. This is not a form of argumentation that is unfamiliar to modern audiences; recent scandals of body mining and other misuses of bodily matter have exposed closet and illegal practices by health professionals who claims to be acting for the collective good (BBC, 2010; Dewar and Boddington, 2004).

In '*Never let me go*', the language and behaviour of those who care for the cloned children make explicit the ways that discourse differentiates bodies and underpins the power relations that enable the sustainable exploitation of some bodies by others. Here new rationales are needed; unlike existing discourses that support racism and slavery through biological arguments or bio-logics (Tyner, 2014), discrimination against the corporeal other cannot be grounded in assumed associations and disassociations of genetics, geographical origin and personality deficiencies; differentiation is not based on outward signs of potential group otherness such as colour, dress or religion but by an inward or invisible otherness defined by the personal provenance of bodies. In the future dystopias where two bodies intentionally share the same genetic make-up through the technology of cloning, superiority and dominance are granted on the grounds of which body is authentically human. This human authenticity is granted to the body that was the original first and whose production was resourced through the convention of two parents; identical 'copies' derived through technology and resourced only by one 'parent' do not count as authentically human and, as such, are accorded no claim to human rights.

The possibilities for full human cloning, on which such discrimination would depend, still seem distant. By contrast, discrimination directed to bodies that fail to accord with socially sanctioned body forms or bodily behaviour is very much evident in the present. Lifestyle choices as a basis for discrimination and bodily exploitation is a theme picked up in Ninni Holmqvist's *The Unit* (2008), a novel which imagines a most plausible future society, a near-future Sweden that has adapted its tradition of a strong collective commitment to the welfare state to encompass a collective response to the demand for scarce organs. At fifty, those persons categorised as non-essential must move to the closed 'Unit' of the title from where they will be involved in drug tests and make donations up to their death. The Unit is luxurious, the inhabitants well looked after; the critical aspect here is who counts as essential and who does not and the Unit is thus populated by those without children, without established partners or not in a valued occupation. This latter may easily be read as not in an economically productive occupation given the disproportionate representation of artists in *The Unit*. Perhaps more importantly, this hierarchy of value accorded to lifestyle behaviours transforms effortlessly into a hierarchy that is understood as an embodied essentialism. When the main character falls in love and becomes pregnant in *The Unit*, she cannot be reclassified. As an artist and as a late parent, she is already fatally designated as unsuitable and her child will be adopted by a 'normalised' family.

These future imagined worlds in turn have their own futures hinted at. Both Holmqvist and Ishiguro indicate the fragility of the good care offered to these donor bodies, hinting at a move towards harsher practices. Once bodies are cast as less valued, as amenable to exploitation to save more valued others, then they are already effectively categorised as lesser humans and the discourse that supports an investment in those bodies can be easily transformed into the very different justifications underpinning dehumanising attitudes and practices of abjection.

This chapter has travelled through lived and imagined engagements with the tensions of scarcity and inter-corporeality in the global practices of organ transplantation to draw our attention to the importance of the different modes of argumentation through which particular practices are justified. In particular, the historical and the potential future blurring of the social and the biological in differentiating bodies as same or different or as more and less valuable takes place within the context of such tensions and the context of increasingly available global markets for medical care. The dominant emphasis in social

science analyses on neoliberalism and globalisation privileges the tensions of scarcity in our analyses of medical tourism, but our analyses need to include reflection on how existing modes of differentiation and discrimination might be reworked, renegotiated or reimagined. Analytical work that can disclose the underlying forms of argumentation that apparently resolve or make invisible the evident tensions of scarcity and inter-corporeality that confront the practices of global transplant tourism is essential work within the processes of on-going social deliberation about our modes of collective involvement with new and emergent medical technologies. Literature and film afford an alternative and complementary source of nuanced data on the range of possible experiences of those whose lives are directly affected by the accommodations made around the tensions of scarcity and inter-corporeality and which shape the practices of mixing and fixing bodies in the global market for health and medicine.

ACKNOWLEDGEMENTS

The research for the paper was supported, in part, through a Wellcome Trust Strategic Award in Medical Humanities at Durham University (Grant number WT:086049). Thanks are due to the editors of this volume, Clare Herrick and David Reubi, for their insightful, supportive and patient editorial inputs throughout the development of this chapter.

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